

Society Reports.

NEW YORK NEUROLOGICAL SOCIETY,

December 5, 1899.

The President, Dr. Frederick Peterson, in the chair.

MULTIPLE SCLEROSIS WITH SYMPTOMS OF PROGRESSIVE MUSCULAR ATROPHY.

Dr. Graeme M. Hammond presented a case of multiple sclerosis occurring in a man, thirty-eight years of age, exhibiting symptoms resembling those of progressive muscular atrophy. This combination, he said, was quite rare. The patient was a locomotive fireman by occupation, and had a good personal and family history. About one month after an attack of the grip ten years ago his present trouble began. The first symptom had been a paralysis of the internal rectus of the left eye, and this had been followed by weakness of the left superior and the right internal rectus. At the present time, in addition to these symptoms, he had left hemianopsia. About one year ago he had had a sudden loss of smell on both sides. About six years ago he had begun to show symptoms of locomotor ataxia. The knee-jerks were absent. Last January he had noticed weakness in the little and ring finger of the right hand. This weakness had extended to the other fingers, and had been accompanied by atrophy. The atrophy was now well marked in both upper extremities, and fibrillar twitchings could be noticed in the affected muscles. These muscles responded slightly to the galvanic current, but not at all to the faradic. This history was very characteristic of multiple sclerosis. In 1897 a similar case had been reported in one of the German journals. In the case presented true intention tremor and scanning speech were not present. It had occurred to Dr. Hammond that the patient might be suffering from a progressive muscular atrophy engrafted upon a multiple sclerosis, but it was also possible that the sclerotic changes had taken place in an unusual position in the anterior horns. The optic nerves had remained normal.

Dr. B. Sachs thought that the case might be almost anything else than multiple sclerosis. This diagnosis did not seem to him justified in the absence of nearly all of the cardinal symptoms of the disease.

Dr. Joseph Collins regarded the case as one of locomotor ataxia associated with progressive muscular atrophy. It was possibly an example of syringomyelia and tabes, like a case he had had under observation for a long time.

Dr. George W. Jacoby agreed with the last two speakers, because

the symptoms in the upper extremities and the optical symptoms resembled those of a nuclear affection, while the symptoms presented by the lower extremities were like those of tabes. It was, of course, rather presumptive to make a diagnosis after Dr. Hammond had studied the case so carefully.

Dr. Frederick Peterson thought that this patient presented all the symptoms of locomotor ataxia. Atrophies of this kind were not very uncommon in locomotor ataxia. Several years ago he had exhibited to this society a case of typical locomotor ataxia with three symmetrical quadrants of vision lost, so that the person saw out of only one-quarter of each eye. He, therefore, looked upon the case as a locomotor ataxia presenting the unusual symptoms already cited.

Dr. Hammond replied that at first he also had looked upon this case as one of locomotor ataxia with ocular symptoms, but, on studying it more carefully, he could not find the slightest indication of syphilitic infection, the man having indeed been singularly free from previous illness of any kind. He was temperate in his habits, was not neurotic and presented an unusually good personal history. Again, his tabetic symptoms had not been at all prominent; the Romberg symptom was hardly noticeable, and there were none of the bladder or sexual symptoms of tabes. The fact that there had been lesions of the optic, the third and the olfactory nerve, coming on respectively at intervals of several years, he looked upon as proof that sclerosis had affected these different nerves. An involvement of the posterior columns in disseminated sclerosis was not at all uncommon. The atrophy in the hands was, however, decidedly unique.

INTRACRANIAL GROWTH.

Dr. Philip Meirowitz presented a man of thirty-eight years, who had come to him on December 1, 1899, complaining of amblyopia of the left eye. He was entirely blind in the right eye from an injury inflicted with a piece of steel. The disturbance of vision had first appeared in the summer of 1898, and had reappeared four months ago. The "blind spells" had come on several times a day, and had lasted about eight minutes each time. They had continued altogether for about six weeks, and had been unaccompanied by pain. A tremor in the right upper extremity had also developed about the same time as the trouble with the eyes. Jerking of the right arm had been quite marked at night. Vertical headache had been present, and quite troublesome some months ago, but had disappeared. About the middle of last July he had been seized with attacks of vomiting after taking food, and had improved under milk diet and the administration of iodide of potassium. About this time he had a sudden loss of consciousness, and again, two or three months ago, he had a similar attack. There was no distinct history of syphilis. Examination showed dilatation of the left pupil and good reaction to light, with absence of nystagmus. Tremor of the right arm was quite marked, and was aggravated by movement. His gait was good; the knee-jerks were exaggerated; there was no ankle-clonus. He had no sensory disturbances. Dr. Valk had examined the eyes with the

ophthalmoscope, and had found a papillitis. There was no mental dullness, and no impairment of the memory. The speaker expressed the opinion that the man had an intracranial growth, and he believed that its location in the cerebellum would account for most of the symptoms. He was inclined to believe that it was a syphiloma because of the effect of treatment with the iodide and the lack of definiteness regarding the absence of syphilitic infection.

Dr. B. Onuf said that the patient had been under his care at the time that he had received the iodide. He had then a staggering gait, a marked intention tremor, increased knee-jerks and ankle-clonus on the right side. His eye showed marked choked disk and a number of retinal hemorrhages. He had at first hesitated between a diagnosis of tumor and multiple sclerosis. Dr. Coffin had expressed the opinion that the shape of the hemorrhages—small and wedge-shaped—pointed rather towards syphilis. The man had then been put upon rapidly increasing doses of the iodide, and had improved promptly. The dilatation of the pupil and the intention tremor were controlled by this treatment. He did not doubt that the trouble was syphilitic, but could not accept the theory that all of the symptoms could be explained by one syphiloma.

Dr. Meierowitz replied that Dr. Francis Valk, in his recent ophthalmoscopic examination, had found the retina entirely normal. The absence of disturbance of speech and of nystagmus and the presence of papillitis seemed to him sufficient to exclude multiple sclerosis. It was, of course; quite possible that there were a number of lesions, but where the symptoms could be explained by one lesion, a diagnosis of a single lesion seemed the more rational.

TWO CASES OF TUMOR COMPRESSING THE CAUDA EQUINA; REMOVAL; RECOVERY.

Dr. B. Sachs reported these cases. He said that in both the symptoms had been relieved by operation. The first patient had been seen on September 3, 1897, in consultation with Dr. Wyeth. The second patient had been seen at the Mount Sinai Hospital in the service of Dr. Meyer. The first patient, fifty-six years of age, had been suffering for eighteen months with severe pains in the lower extremity and, more recently, with spasm of the muscles. He had been shot in the leg during the civil war. When seen by the speaker he had presented marked cachexia, severe pain and violent spasm. The pain was neuralgic in character, and radiated from the lumbar region of the spine down the posterior aspect of the thigh to the foot. The spinal column was not specially sensitive except over the second lumbar vertebra, at which point pressure elicited pains like those complained of ordinarily. There was a distinct diminution of tactile, pain and temperature sense at the upper and inner portion of the right thigh. The right knee-jerk was absent. The vesical and rectal reflexes were not impaired. The neoplasm was probably extradural, because, if in-

tradural, the symptoms would have been more symmetrical. Dr. Sachs had urged Dr. Wyeth to operate for the removal of the growth, and the operation had been done at once. Upon exposure of the spinal canal a tumor, the size of a small cherry, was revealed, adherent to the dura and bone. Microscopical examination of this mass showed it to be an alveolar sarcoma. As much as possible of the diseased tissue had been removed. Five days after operation the patient had been able to be up and around, and had been remarkably comfortable. The spasms had ceased. One month after operation the patient had been able to return to his home in the South.

The second patient was thirty-nine years of age, and had been admitted to the Mount Sinai Hospital on October 9, 1899. Some years ago he had been told that he had pulmonary tuberculosis, and had lived in California until apparently cured. The patient was of emotional temperament. He had come to the hospital with a diagnosis of locomotor ataxia. About one year ago his first symptoms had appeared. Examination had shown normal reaction of the pupils; no tremor of the tongue or face. There was a distinct kyphosis involving the twelfth dorsal and three upper lumbar vertebræ, but there were no tender points except between the third and fourth lumbar vertebræ. There was no marked interference with the vesical and rectal reflexes. The physical signs in the lungs were suggestive of tuberculosis. He had no strictly ataxic symptoms, but had distinct paresis of the lower extremities. The strictly unilateral character of the sensory changes pointed to a growth in the lower portion of the spinal column, but in deference to those who thought it possible that tuberculosis of the spine existed, suspension and fixation of the spine had been attempted. This had yielded an entirely negative result. The disease was evidently progressive, and mercurial and iodide treatment proved negative. On November 10, at Dr. Sachs' suggestion, Dr. Gerster performed laminectomy on the second and third lumbar vertebræ. At this operation a gelatinous mass was exposed, and the body of the third lumbar vertebra was found to be invaded by the disease. The tumor extended only to the lower margin of the second vertebra, and was removed. It had evidently compressed the cauda equina. Sections of the tumor showed it to be a small-cell sarcoma. Three days after operation sensation in the leg seemed to be improved. Improvement had been steady, but the patient had been compelled to remain in bed. There was reason to hope for at least a temporary recovery—certainly life had been prolonged by the operation.

Commenting upon these cases, Dr. Sachs said that the first

case had been diagnosticated as a chronic neuralgia previous to coming under his observation. The bilateral distribution of the pain, the absence of marked vesical and rectal symptoms, had seemed to him to point to the cauda equina, and not to the lumbar enlargement, and the tender spot had served as a valuable guide in both cases. There were few chronic spinal processes that followed the slow course of such spinal tumors. An exploratory laminectomy, if properly done, was practically harmless, particularly if done in the lumbar or dorsal regions.

Dr. Joseph Collins said that the cases presented should be a cause for much congratulation to the reader of the paper, as well as to the surgeon who operated. He felt sure that the mortality in these cases was not so great that neurologists should not be on the alert to diagnose them and urge operative intervention.

Dr. Peterson added his congratulations to those of the last speaker. It seemed to him that tumors in this particular locality were more difficult of diagnosis than in other portions of the cord. One important feature of the paper was the aid that the sensitive area or the deformity had given in establishing the diagnosis.

Dr. Sachs, in closing, emphasized the point that even if the sensory changes were very slight, they should be reckoned with in making the diagnosis. This had been well exemplified in the first case. Another point insisted upon was that he had managed by pressure upon a definite point to elicit the same pain as that of which the patient had complained. This had been very well marked in the first case.

DYSPHRENIA.

Dr. William Hirsch read a paper with this title. He said that the term "dysphrenia" had been applied to the secondary or sympathetic psychoses in contradistinction to the idiopathic or mental diseases, such as mania and melancholia. The secondary psychoses, which are produced by bodily diseases, are not characterized by the same uniformity of symptoms that mark the idiopathic variety. In the secondary psychoses there were frequent remissions with perfect lucidity during the course of the disease. Outbreaks of violence might be quickly followed by stupor. The speaker said that a further characteristic which he would call attention to was the occurrence of somatic symptoms, as loss of pupillary or patellar reflexes, rise of temperature, irregularity of the heart action and certain vasomotor phenomena, such as edema. In the secondary psychoses, the interstitial tissues, and particularly the blood vessels, were the ones at first and mainly affected. This was in accordance with the accepted pathology of the systemic spinal diseases. The changes in the interstitial tissues were produced by the diseases starting outside of the brain, such as the acute febrile diseases. There were a few cases in which, purely from the mental symptoms, one was justified in making a diagnosis of dysphrenia, even though ignorant of the exact nature of

the underlying bodily disease. A case of this kind was then reported by Dr. Hirsch.

The patient was a young and neurotic girl, seen by him first on September 5, 1896. She had then presented the condition of hallucinatory confusion. After an interval of quiet, on February 17, 1897, she became violent, and developed hallucinations of hearing and sight. At this time the temperature was normal. After about ten days she became stupid; her pupils were contracted, and the pulse was sixty. After about one week, automatic movements of the hands and head appeared. On March 14 menstruation came on, and she quickly became normal, and remained well for ten days. In April, 1897, she was given thyroid extract, and quickly recovered. She remained well for nearly two years. On February 2, 1899, she unexpectedly developed the same violent symptoms as before. She showed some transitory improvement again under the administration of thyroid extract, but soon passed into a condition of dementia. After about three months she became quieter; the pupils and patellar reflexes returned; the temperature became normal and her breasts, which had been much enlarged, returned to their natural size. Since that time her mental state had been good. The clinical features of this case evidently did not correspond to any primary psychosis. A loss of reflexes was generally considered as indicative of permanent change, but it was not impossible that this symptom might exist in functional disturbance. In the case just reported he believed that the menstrual disturbances were not the cause, but a symptom of the disease, as in the fourth, or worst attack, menstruation had had little or no effect on the mental state. The speaker suggested that the term "originary dysphrenia" should be applied to those cases, which, in their clinical aspects, resembled those known to be produced by toxic or infectious agents, but in which no cause for such infection could be found.

Dr. Brown said that he had seen a number of somewhat similar cases presenting apparently a physical basis for the mental disorder. In some cases of even very severe mental disease the mental symptoms would clear up during the later stages, for example, of a tuberculosis.

Dr. Mary Putnam-Jacobi asked Dr. Hirsch if he looked upon general paresis as a secondary psychosis, and also in what way the case of dysphrenia reported by him differed from recurrent attacks of hysterical insanity; also how far the failure to distinguish personality was really a mental symptom and how much the result of personal caprice.

Dr. B. Sachs said that probably all present had seen cases similar to the one described. He had himself had under observation a number of women between the ages of fifteen and twenty who had passed through very remarkable periodical mental changes. He had been much impressed with the suddenness with which these changes had

occurred. All of these patients had been members of strongly neuro-pathic families. They had passed quickly from a condition of mania to one of depression. A patient now under his care had regularly had periods of six months or more in which she had been in a condition of maniacal excitement, and had then very suddenly passed into an apparently normal condition, but really only a steppingstone to a period of excitement. It was questionable in his mind whether the class of cases spoken of in the paper represented a distinct entity in mental diseases. Such marked physical changes as described in the paper had not come under his observation.

Dr. Peterson expressed his belief that dysphrenia would be a convenient term for those cases that it would be difficult to describe under other names. The trouble was that these terms in psychopathy were usually founded upon clinical symptoms, with but little reference to the pathology, so that after a time the word came almost to include all insanity. Last summer, at Heidelberg, he had found about four varieties of insanity recognized, viz.: paresis, senile dementia, catatonia and dementia precox. About fifty per cent. of the cases in Germany at the present time were called catatonia, and the balance were included under the term dementia precox.

Dr. Hirsch closed the discussion. He said that it was certainly remarkable how many insane patients would pass through a disease like typhoid fever without developing any mental symptoms—indeed the patient whose history had been given had just passed through a typhoid fever in this way. He too recognized the great evil that had resulted from introducing names into psychiatry, but dysphrenia was not a new name, and certainly was useful in connection with a case like the one reported, which could not be well placed in any other classification. Dr. Sachs had referred particularly to circular insanity—to cases essentially chronic in their nature—but he had been discussing cases that were really acute. The mental disease consisted of a series of psychopathic conditions. The diagnosis of dysphrenia could only be made from a detailed history and long study. By a primary psychosis he meant a mental disease originating in the parenchyma of the organ; by a secondary psychosis one originating in the interstitial tissue; hence general paresis would be a secondary psychosis.

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13. PARALYSE UND TABES BEI EHELEUTEN (General Paralysis and Tabes in Husband and Wife). Raecke (*Monatsschrift für Psychiatrie und Neurologie*, 6, 1899, p. 266).

Raecke has observed seven cases of parietic dementia in husband and wife, and in two of these syphilis positively occurred. There seem to be only 69 cases in the literature, omitting those of Crété and of Gottschalk recently published, and including Raecke's, of tabes or general paralysis in married couples, but probably the small number is due to imperfect observation. Syphilis was present 38 times in these 69 cases, and a history of probable infection was obtained in ten other cases. It was positively denied in two cases. General paralysis occurred in both husband and wife 27 times, general paralysis occurred in the man and tabes in the woman 14 times, tabes occurred in both 22 times, general paralysis in the woman and tabes in the man 6 times. It appears from these cases that the man is more liable to general paralysis than the woman, and that he shows the affection first, as demonstrated by 24 cases in which the husband first manifested disease and 9 cases in which the wife was first affected.

SPILLER.